VOLUNTARY COUNSELING AND TESTING (VCT) AND YOUNG PEOPLE

A SUMMARY OVERVIEW

JUNE 2002

By Deborah Boswell and
Rachel Baggaley for
Family Health International

Material for this summary document was drawn from a larger document produced by FHI and UNICEF. Contributions were made by Gloria Sangiwa, Lisa Simutami, Donna Futterman, Ann McCauley, Andrew Boner, Buhle Ncube, Mags Beksinska and Georgina Mutale.

This summary provides an overview of evidence-based data, current experiences, lessons learned, issues for consideration, strategies and recommendations for creating an effective framework for VCT services for young people.

It is designed to be used by program planners; organizations providing services to young people or intending to strengthen their existing services by catering to youth populations; staff within government ministries including ministries of health, ministries of youth and ministries of education; and current and potential donors.

Material is relevant to the contemporary context, but this is a dynamic and emerging field with ongoing lessons to be learned and increasing field experiences to draw upon.

This document may be freely quoted, reproduced and translated, in part of in full, provided the source is acknowledged. The authors acknowledge the input and reflections provided by all contributors as well as technical input from the UNAIDS Secretariat and WHO.

This guide has been funded by USAID through FHI's Implementing HIV/AIDS Prevention and Care (IMPACT) Project, Cooperative Agreement HRN-A-00-97-00017-00.

TABLE OF CONTENTS

VCT AS AN ENTRY POINT TO PREVENTION AND CARE SERVICES

Voluntary HIV counseling and testing is the process whereby an individual or couple undergo counseling to enable him/her/them to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual/s and he/she/they must be assured that the process will be confidential.

VCT is much more than drawing and testing blood and offering a few counseling sessions. It is a vital point of entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, TB control, psychosocial and legal support, and prevention of mother to child transmission of HIV. High-quality VCT enables and encourages people with HIV to access appropriate care and is an effective HIV-prevention strategy. VCT can also be an effective behavior-change intervention. VCT offers a holistic approach that can address HIV in the broader context of peoples' lives, including the context of poverty and its relationship to risk practice.

VCT offers benefits to those who test positive *or* negative. VCT alleviates anxiety, increases clients' perception of their vulnerability to HIV, promotes behavior change, facilitates early referral for care and support—including access to ARV therapy—and assists in reducing stigma in the community.

There is demand for VCT (people want to know their HIV serostatus), and demand can also be created when comprehensive services are made available and stigma is reduced. An increasing number of countries are rapidly addressing the quality and quantity of care-related programs. Care-related activities include increased access to ARV therapy. VCT services must be made more widely available given this dynamic context and that access to care (including ARVs) requires people to know their HIV serostatus.

A RATIONALE FOR INVESTING IN YOUNG PEOPLE

For the purposes of this document, "young people" or "youth" will refer to those aged 15-24 years. The majority of young people in this group who may be at risk for HIV infection are those who engage in unsafe sex. But young people often start sexual activities before this age, which will be discussed in relation to the legal and ethical dilemmas associated with VCT for this group. Young people may also be at risk for HIV infection from unsafe injection drug use (IDU), exposure to contaminated blood and blood products or unsterilized skin-piercing procedures (e.g., tattooing or traditional medical practices such as scarification).

There are more teenagers alive today than ever before: 1.1 billion adolescents aged 10-19 years, 85 percent of them living in developing countries.[1]

Young people aged 15-24 account for more than 50 percent of all HIV infections worldwide (excluding perinatal cases). More than 7,000 young people are newly infected with HIV each day throughout the world. In Africa alone, an estimated 1.7 million young people are infected annually.[2]

Preventing HIV among young people is particularly urgent in sub-Saharan Africa, where in many countries young people comprise more than 30 percent of the population and general HIV prevalence rates often exceed 10 percent.[3]

In the United States, AIDS is the leading cause of death in African-American young people aged 15-24.[4] Also in the United States, at least 25 percent of all new HIV infections are people under the age of 21.[5] Although prevalence in the general population remains low in Russia and the Newly Independent States, young people are becoming increasingly vulnerable to HIV.[6]

In Nigeria, the first populous country to have an average national HIV prevalence rate of >5 percent

(Nigeria's overall national HIV prevalence rate was 5.4 percent in 1999), "youth" (defined by the Nigerian National Action Committee on AIDS as 20 to 24 years of age) show the highest seroprevalence rates (4.2-9.7 percent). Since 1995, HIV prevalence rates among youth in the most affected state have increased by more than 700 percent. VCT for young people has been recognized as a major priority within the Nigerian HIV-prevention program.[7]

Table 1: HIV prevalence rates among young people (15-24 years), end 1999

Country	Estimated HIV prevalence rates	
	Young women	Young men
West Africa		
Côte d'Ivoire	6.7-12.3	2.1-5-47
Nigeria	4.35-5.89	1.68-3.35
Senegal	1.12-2.07	0.39-1.02
East Africa		
Kenya	11.07-14.98	4.26-8.52
Tanzania	6.85-9.27	2.64-5.28
Uganda	6.65-8.99	2.56-5.12
Southern Africa		
Botswana	32.55-36.07	13.68-18.00
Mozambique	13.36-16.11	4.49-8.97
South Africa	22.51-27.13	7.56-15.11
Zimbabwe	23.25-25.76	9.77-12.85
Zambia	16.86-18.68	7.08-9.32
Asia		
India	0.4-0.82	0.14-0.58
Thailand	1.53-3.11	0.47-1.89
Eastern Europe		
Russian Federation	0.09-0.15	0.19-0.32
Ukraine	0.6-0.98	0.95-1.63
United States	0.16-0.3	0.15-0.44

Source: UNAIDS, *Report on the Global AIDS Epidemic*, June 2000 (adapted).

VCT'S RELEVANCE TO YOUNG PEOPLE

VCT is part of a package. The more general needs of young people, children, families and couples must also be addressed as part of providing comprehensive services. Young people actively seek and receive VCT even where VCT services have not been designed specifically for them. The AIDS Information Center (AIC) in Uganda has reported an increase in the number of youth seeking VCT, especially for pre-marital testing.[8,9,10] About 15 percent of AIC clients are between 15- and 19-years-old. By the end of 1995, 39,000 adolescents had visited the center. Of these adolescents, 78 percent were females and 40 percent came to the center with their sexual partners.

In Zambia, 14.6 percent of attendees at the Hope Humana VCT site in Ndola were 10- to 19-years-old.[11] Uptake of VCT by young people (aged 13-19 years) is reported to be increasing in Brazil.[12] Forty percent of those attending the ATC site in Bangkok, Thailand, described themselves as "students." In the United States, 900,000 records of people who had undergone HIV testing were reviewed: 13 percent of them were 13- to 19-years-old.[13]

Few countries have VCT services specifically developed or adapted for young people. This is important as the reasons for seeking VCT services, outcomes and needs following VCT can be different for young people.

Some countries are now acknowledging the importance of targeting youth in their HIV prevention and care strategies and include VCT for youth in their agenda. Draft national guidelines for the Republic of Ghana state that it shall "seek to ensure the expansion of the access of young people to youth-friendly facilities and services including HIV and STI (sexually transmitted infection) prevention, management and testing, counseling and the provision of care and support services."

Because of the long latency period between HIV infection and development of AIDS, deaths from infections that occurred in the early 1990s are only now being experienced. Many countries have yet to experience significant mortality in the 20- to 24-year-old age group, particularly within new and emerging epidemics, such as Nigeria.

In the United States, there are now 2,400 adolescents who were born with HIV and thousands more who will turn 13 over the next five years.[14] Such children and young people may have counseling needs—for such issues as disclosure, negotiating safety, care and support—as they reach new stages in their development and lives.

DIVERSITY AMONG YOUNG PEOPLE REQUIRES APPROPRIATE SERVICE MODELS

Because young people naturally reflect their communities, the variety of their behaviors and practices is diverse in the same way as adults'. Knowing how young people are infected and affected by HIV/AIDS in a given context is important in developing effective service delivery models. VCT services may have to be general or targeted depending on a range of factors including HIV prevalence, health-seeking behaviors, level of stigma, access to hard-to-reach groups and supportive legal and policy environments. Below are some of the things that must be considered in responding to specific groups.

Reaching vulnerable young people—including those who have experienced sexual abuse, those with drug (including injection drug use) and alcohol abuse issues, young men who have sex with men and those engaging in sex work—is an important challenge. These youth *may* be at increased risk for HIV infection. *Few services have been developed to help young people in developing countries who are at increased vulnerability to HIV/AIDS as a result of risk practice or exposure.* In Uganda, the NGO "Hope after Rape" provides support to young people who have been raped or abused. Development of this type of service is a high priority.[15]

Risk of HIV infection through injecting drug use is a significant concern in many industrialized countries and in parts of Asia and Eastern Europe. Providing VCT and counseling services to reach IDUs (who include young people) provides particular challenges and requires innovative, targeted interventions such as those used for harm reduction in parts of Thailand, India and Australia. There are no specific VCT models to date targeting young IDUs. VCT for this group needs to be explored as part of a more comprehensive approach to basic health service delivery, such as those that might be offered through mobile clinics, needle exchanges or integrated via drug and alcohol facilities, including detoxification units.

Challenges for VCT Service Provision for Young Drug Users

- Illegality of IV drug use;
- Stigma and secrecy associated with IDU;
- Seen as a low priority and lack of political will;
- Lack of acknowledgement of HIV as a problem among IDU population
- Lack of resources and services available for IDUs. Funding of services for IDUs is also excluded from the mandate of some donors;
- "Hard-to-reach" population. Health-seeking behaviors may be different;
- Frequently associated psycho-social issues for IDUs;
- Punitive rather than prevention and care approach to IDU;
- Needs of IDUs in juvenile detention centers, etc. ignored.

HIV poses a significant threat to uniformed service populations, including military personnel, peacekeepers and police. This is particularly true during complex humanitarian emergencies. A large number of uniformed service personnel are young males. UNAIDS, the World Bank and FHI are currently providing funding and/or technical support to target VCT-related activities to uniformed services in Eritrea, Ethiopia, Ghana and Rwanda. Constraints to providing VCT for some of

these groups (including the military and especially new recruits) include mandatory testing requirements enacted by some governments. Desirable interventions could lobby for reform of mandatory testing *and/or* encouraging governments to ensure that pre- and post-test counseling, sharing of results with the individual who has been tested, and adequate referral to care and support services take place during the mandatory testing intervention. In addition, VCT services need to be made available to uniformed service personnel even *during the time of their service* given the high degree of risk practices that often occur in the field.

In many developing countries, homosexual sex is illegal between men who are less than 18 years of age. In some developing countries, particularly in sub-Saharan Africa, all homosexual sex is illegal. Nevertheless, many young men have sexual relationships with men and are vulnerable to HIV infection. Young men who are involved in non-consensual sex or sex work are at particular risk of HIV infection and may be reluctant to access formal medical or preventive services.[16] Some young men who engage in homosexual sexual practices do not identify as "homosexual" or "MSM" or may have transient homosexual experiences. This is particularly noted for young men in prison and other institutions.

The need for sex education counseling and HIV awareness and prevention is often overlooked for young people with special educational needs, low levels of literacy, etc.. Successful approaches have been developed and can be adapted for young people with special learning needs.[17]

MANY APPROACHES BESIDES VCT CAN MEET YOUNG PEOPLE'S HIV/AIDS-RELATED NEEDS

Young people have a broad range of HIV/AIDS-related needs. Services must be developed to respond to these needs, and where not housed in a "one-stop shop"—desirable for some youth subgroups—strong linkages must be forged with such places. Some needs may be best met by counseling, although the needs of other young people are better met through access to comprehensive health education and opportunities for quality life skills training.

Needs that may require attention include:

- Peer pressure
- Assertiveness and negotiation skills
- Self-esteem
- Risk-taking and experimentation as related to developing safer behaviors and setting limits
- Alcohol and other drug use and abuse
- STIs, including HIV
- Contraception
- Condoms and overcoming barriers to ensure safe and effective use
- Sexual and intimate relationships
- Familial relationships
- Abuse (sexual/physical/emotional)
- Domestic violence
- Rape
- Pregnancy and fertility issues
- Safe abortion
- Sexual identify issues
- HIV/STI disclosure issues
- HIV treatment-related issues (adherence to ARV therapy, coping with adverse effects, treatment failure)

It is clear that young people value opportunities for counseling and that more than one session is required to adequately explore most of the above-mentioned needs.

Supporting young people in VCT

During pre-test counseling, the counselor *may* need to:

- Explore their reasons for presenting and provide unconditional support.
- Affirm their courage in seeking services and encourage their attempts to practice healthful behavior.
- Assess their risks, perceptions and factors relating to vulnerability.
- Outline the test procedures and practice and find out what a positive or negative result would mean to them and to whom they would disclose their status.
- Ask about their existing support systems.
- Take the opportunity to provide health education and/or information as required (including modes of transmission and prevention, condom demonstration and distribution).
- Help them understand how they can reduce their risk, perhaps using role-play.
- Offer an opportunity for them to ask questions and communicate their concerns.
- Refer them as appropriate to generic or specialized counseling, drug and alcohol services, abuse and domestic violence services, medical services, support groups, peer support, personal, legal and financial services, religious organizations, etc.
- Distribute IEC materials as appropriate.
- Facilitate or mediate familial and spousal support as desired and appropriate.

During post-test counseling, the counselor *may* need to:

- Explore their readiness to receive test results.
- Explore how things have been and what may have changed since the last meeting if not on the same day as the pre-test.
- Revisit risk assessment and risk-reduction planning as required.
- Take the opportunity to role-play/practice behavior modification.
- Offer additional health education and/or information as required (including modes of transmission and prevention, condom demonstration and distribution).
- Allow them to ask questions and communicate their concerns.
- Revisit the matter of their support systems, disclosure and coping capacity (especially when the result is positive).
- Refer them as appropriate to generic or specialized counseling, drug and alcohol services, abuse and domestic violence services, medical services, support groups, peer support, personal, legal and financial services, religious organizations, etc.
- Distribute additional IEC materials as appropriate.
- Facilitate or mediate familial and spousal support as desired and appropriate.
- Plan for additional or ongoing support as possible and desired.

A recent report from Horizons based on a small sample of 14- to 21-year-olds in Uganda and Kenya found that 20 percent of the young people who undertook VCT reported that they were not sexually active.[18] Personal communication with the research investigator revealed that at least some of the young people were seeking VCT simply to have access to information. This finding begs many questions that must be answered in order to tailor services more effectively to the needs of young people—including the need to further explore the derived value of VCT for them and their motivation for testing. It may also suggest that ***other services such as counseling, life skills training, health education and hotlines may more appropriately meet the needs of some young people and/or be mutually reinforcing***.

YOUNG PEOPLE'S HEALTH-SEEKING BEHAVIOR OFFERS LESSONS FOR VCT

Patterns of health service use differ for young people by setting and among different groups. Young people in industrialized nations also have different patterns of health services use, particularly for reproductive health and STI/HIV health services.[19]

Many of the lessons we have learned about young people and sexual and reproductive health services correlate with their VCT needs.

Young people often do not attend formal health services for their preventive health needs. Instead, they may seek sexual and reproductive health (SRH) services in a variety of settings, such as government health facilities, private clinics, chemists, friends and, in some countries, traditional healers.

When young people in Zambia were asked where they went for SRH services outside of formal health centers, the top three responses were traditional healers (44 percent), private clinics (32 percent) and friends (8 percent).

Young women are reportedly much more likely to present late in pregnancy for antenatal care and less likely to deliver in a health facility or be attended at delivery by a skilled birth attendant. This contributes to higher infant and maternal mortality among young mothers and is also an important factor when considering VCT for prevention of mother-to-child transmission among young pregnant women.

Interventions aimed only at young women are likely to be less successful than those that address the needs, roles and responsibilities of both young men and women.

Single-session educational classes have been shown to be ineffective whereas multi-session, small-group activities—involving young people in their design and development and providing access to counseling and VCT—are more successful in promoting safer sexual behavior.[20]

Key features of youth-friendly health services

- **Full participation of young people** in decision-making, planning and delivery of services
- **Community mobilization** to increase understanding of young people's health needs
- **Peer education** through community outreach and clinic-based educators, and compensation packages to ensure participation and motivation
- **Designated "youth-friendly corners"** at clinics and freestanding VCT sites
- **Health providers trained** in youth-friendly approaches to communication and counseling
- **Suitable accommodation** ensuring discretion for issues of consent and disclosure
- **Integration** with other post-test health and psychosocial support services
- **Confidentiality**
- **Adequate supplies of condoms, IEC materials and drugs**

THERE IS NO IDEAL MODEL FOR VCT SERVICES FOR YOUNG PEOPLE

Type of model	What we know	Issues for consideration
Integrated into primary health care (e.g., youth-friendly corners in clinics)	Young people are often reluctant to attend formal health services, and reproductive health services reach few adolescents. There is no "magic bullet" to get unmarried adolescents to increase use of clinic-based services. This has led to support for youth-friendly health services (YFHS). Adolescent reproductive health services may be more effective at influencing knowledge and attitudes than behavior. "Youth-friendly" initiatives appear to work better when combined with other outreach strategies to attract youth to clinic-based services.	VCT and counseling services can be integrated into YFHS[21] easily and relatively inexpensively if VCT is already available in primary health care settings. There is no hard evidence to suggest that YFHS are effective or that YFHS successfully increase young people's use of health services.
Integrated into school and college health care services	School or college health services can integrate VCT. A study from the United States proposed that school-based clinics provide easier and more acceptable access to VCT services than other formal health settings.[22]	No VCT models within schools were identified that could be replicated or adapted, although a mobile service in Uganda run by the Kitovu Mission Hospital has successfully provided mobile VCT in school settings.

Type of model	What we know	Issues for consideration
Tuberculosis and antiretroviral (ARV) service access is a model with potential	VCT can be offered to people attending TB services. Likewise, TB and other medical services can be provided for people living with HIV/AIDS (PLHA) following VCT.	ProTEST advocates an integrated approach to VCT and HIV care services (including TB, STI and family planning). In Brazil, services are being developed to provide VCT for young people who present with TB.[23]
Integrated with STI services, family planning clinics, etc: An unlikely model for young people.	Unless services are truly "youth-friendly" this is unlikely to be a key model. There are some successful examples in industrialized countries (e.g,. the Archway Center in North London, which attracts large numbers of young people <www.archwayclinic.org.uk>).	Uptake in many sites is low, as many young people do not favor services within hospitals/clinics (due to service provider attitudes, access issues such as parental consent for services and judgmental approaches).
Youth centers: Scope for counseling services, some scope for VCT	Although there are cautions in using such sites for VCT—including ensuring confidentiality, testing quality and providing adequate referral networks for positive young people—there is room to increase the delivery of counseling through these sites.	Innovative approaches to integrating counseling with youth culture—such as music and drama—have been developed in the United States[24] and some African settings (e.g., Botswana, Uganda, Zambia and Nigeria).
Mobile services: Scope for hard-to-reach populations	Mobile VCT services have been developed in an attempt to access hard-to-reach individuals. The mobile unit can be a van/caravan that offers VCT in situ and makes scheduled, announced visits to particular places. Most established mobile services are in industrialized countries. Feedback through personal communication with U.S.-based service providers suggests there has been limited uptake by young people.	The Kitovu Hospital Mobile Home Care Program in Uganda has a van that visits rural outposts. At one outpost, the van parks on the premises of a local school to offer same-day VCT services to young people. Malawi and Zambia are also exploring mobile service delivery, though these may be targeted less to youth and focused more on reaching rural locations.

Type of model	What we know	Issues for consideration
Private sector: VCT service delivery needs to be strengthened	In countries in West Africa and Asia, private health practitioners deliver much of the primary care. HIV testing is carried out in these settings, often without adequate pre-test counseling or informed consent and with insufficient quality control of testing. VCT (or more often, HIV testing alone) in this setting is usually carried out as part of clinical care, often to confirm clinical suspicion of HIV disease.	There is potential to improve VCT in the private setting. Although there have been some small-scale efforts to train private practitioners to offer better VCT services, such as in Nigeria,[25] there has been little emphasis on improving VCT services for young people in the private sector.
Home testing: Not VCT per se and <u>not</u> a desirable model	Given concerns about confidentiality, some individuals prefer home test kits. But the potential harm outweighs the few advantages for wider global use at present. There are no data demonstrating potential positive impact of home testing in comparison to VCT.	Home testing has many disadvantages: results may be inaccurate or misinterpreted; it reduces uptake of appropriate pre- and post-test counseling; and it does not facilitate referral for the individual.

WHAT HAVE WE LEARNED SO FAR? EIGHT CASE STUDIES

Centro de Medicina Reproductiva Y Desarrollo Integral del Adolescente: A school-based sexuality education and integrated health service program in Chile

Centro de Medicina Reproductiva Y Desarrollo Integral del Adolescente (CEMERA) in 1994-1995 implemented a school-based educational and service-linked program for students in grades 7-12 in two public schools in Santiago.

- Teachers were trained to teach sexual and reproductive health in the classroom.
- Students were referred to the CEMERA clinic, which was open daily for all adolescents and provided free counseling and medical services.

Project outcomes reported:

- There was an increase in knowledge and more responsible and mature attitudes toward sexuality by young people who completed the program.
- Males in the program became sexually active at a later age than the norm. Female students in the program initiated sex at later ages than girls in the schools where the intervention did not occur.
- Contraception use increased among sexually active boys and girls in the program schools.
- The number of unwanted pregnancies decreased.

Factors attributed to the success:

- Engaging students in the design of the curriculum
- Involving parents in a parallel course
- Ensuring availability of linked clinic services that are easily accessible and close to the school to address health needs and provide contraception
- Training teachers increased course sustainability
- Lobbying public officials led to program implementation

Website: www.cemera.uchile.cl E:mail: cemera@uchile.cl

Peer education via schools and community centers to promote VCT for young people

The adolescent AIDS program of Montefiore Medical Center in the Bronx, New York, United States, developed a one-day training program for peer educators.

- Teenagers were recruited through existing peer education programs at schools and community centers.
- They signed pledges and were paid US$100 for 25 hours of work, during which they were assigned to work in neighborhoods where teenagers are at high risk for contracting HIV.
- They visited schools, community centers, ice-skating rinks and parks, informing other young people about the risk of infection and encouraging them to get tested.

Kara counseling and training trust, Zambia: Comprehensive services in a freestanding site

Kara Counseling and Training Trust has been a pioneer in developing VCT services. Hope House, its freestanding site, opened in 1992 and is still widely active. Onsite services include:

- Free pre- and post-test counseling
- Minimal or no-cost same- or next-day HIV antibody testing
- Supportive counseling
- Support groups
- Free (WHO) or low-cost (Maximum/Reality) condoms
- Entry for PLHA to onsite skills training, including batik, tailoring and other income-generating activities
- Family counseling

Value-added services offered offsite by Kara to which young people may be directly referred include:

- Skills training for adolescent girls who are orphans
- Post-test clubs for all individuals irrespective of the outcome of their HIV serostatus (the majority of club members are youth)
- Hospice care
- TB preventive therapy (as appropriate)
- Positive speaking/outreach to schools and other organizations

Additional services offered by partner organizations to which Kara refers:

- PMTCT projects
- Home care
- STI screening and treatment

AIDS Information Center (AIC), Kampala, Uganda: Increased uptake by young people over time

The AIDS Information Center (AIC) in Kampala, Uganda, grew from one site in 1990 to 51 sites by 2001, with a cumulative total of more than 500,000 clients.

The ages of VCT clients in 2000 were as follows:

- 15-19 years: 10 percent
- 20-29 years: 46 percent
- 30-39 years: 29 percent
- 40+ years: 15 percent

Services include:

- Rapid testing with same-day results
- Syndromic STI management
- TB information and preventive therapy
- Family planning
- Linkages to support services, including TASO
- Positive speaking in schools and other institutions via members of the Philly Lutaaya Initiative

The Adolescent Counseling and Recreation Centre (AcRC)

The Adolescent Counseling and Recreation Centre (AcRC) was launched by the Kenya Association of Professional Counselors (KAPC) on Feb. 1, 2001, in response to youth VCT needs. KAPC felt youth needed a non-medical, youth-friendly, affordable, accessible and confidential center supported by trained counselors who are sensitive and non-judgmental toward youth issues.

Services are open to people between the ages of 15-30 and VCT is provided in a youth-friendly environment. The center offers:

- "Same-hour" HIV testing using simple/rapid tests
- Ongoing preventive and supportive counseling
- AcRC Club
- Awareness-raising and mobilization for VCT
- Recreational activities to facilitate further interaction and relaxation
- Correspondence on youth issues through the mail
- Referral to other services is not available at the center
- Networking with other organization dealing with youth, HIV/AIDS, etc.

Approximately seven percent of clients are infected. The center attracts youth from all walks of life and from a vast geographical region. There are more male than female clients. The main reasons clients seek VCT include unprotected sexual intercourse, wanting to get intimate, premarital, believing that they are already infected, STI infections, pre-university or employment.

Lessons learned to date:

- Counselors find it less challenging to counsel self-referred youths than those who are referred. Youth couple counseling is a big challenge for counselors.
- Clients seem to disclose more information regarding personal risks after the test results are known during post-test counseling. Although young people have a high level of knowledge about HIV/AIDS, the internalization or conceptualization of their own potential risk is very low. Clients expect a negative HIV result despite exposure, and a positive result is usually devastating.
- Same-hour results are preferable to the many days of waiting offered elsewhere; if clients are given appointments to come back another day they are not likely to do so.
- Youth are more informed and open than their parents to information about HIV/AIDS, and more prepared for the results. Most youth prefer not to disclose their HIV status to their parent(s) because they fear rejection, discrimination, isolation and how if may affect the parent(s) who have made sacrifices for their education. Some claim that because their parents are already stressed with life it would be unfair to stress them further with positive HIV results.
- Restrictive, unclear public policies concerning this age group are a challenge.
- The centers to which AcRC clients are referred are very unaccepting of adolescents' sexual behavior and disapproving of condom distribution to young clients.
- Many of the youth who frequent VCT centers are stigmatized; it is not uncommon for people to describe the AcRC as an "HIV center."
- Youth appreciate being involved in the planning of their services, evidenced by the formation of the AcRC Club, where both tested and untested youth meet regularly.
- Regular counseling supervision can rejuvenate counselors to be more supportive in counseling adolescents.

Center Dushishoze: A youth center offering VCT in Rwanda

Center Dushishoze is a youth center in Butare, Rwanda, managed by Population Services International (PSI). It opened in January 2001. Between January 9-September 9, 2001, 23,016 youth visited the center; more than 77 percent were young men; 83.6 percent of clients visit the counseling service for VCT; 16.4 percent were counseled for other reproductive health reasons. All clients presenting for VCT between March and August opted to be tested; 93.12 percent were negative; 2.94 percent were positive; and 3.94 percent were indeterminate. Of the 1,599 tested to date, 112 (approximately 7 percent) were repeat visits for confirmation/control after three months.

Additional activities include:

- Peer education sessions (sketches/videos on behavior-change communication themes, discussion of activity and theme, condom demonstration and IEC messages to complement BCC messages).
- Peer educators visited by youth in their homes.
- Counseling on STIs, family planning and pregnancy.
- Activities targeted to parents to increase support for behavior change among youth.
- Promotional competitions and prizes (pens and t-shirts).
- Publicity campaign including posters, billboard and media spot.
- Youth newspaper entitled *Indatwa Z'ejo* (Heroes of the Future).
- Basketball and volleyball courts (located next to the center).

Lessons learned: Attempts to increase the attendance of girls have resulted in offering free skills-building sessions to girls in hairstyling, embroidery, English and basic literacy. Hair styling is the most popular. Each course lasts three months. Since commencing these activities, girls' attendance at the center has risen from 14 percent to 38 percent. Day class days have become unofficial "girls days" when girls now come to "hang out."

A behavior change project cannot be successful without the support of parents—including their approval of the center—and conducting BCC with parents to get them to talk to their children and to support preventive behaviors, such as condom use among their children.

Outreach VCT in Zimbabwe: Lessons learned to date

(A strategy of the Ministry of Health and Child Welfare coordinated by the HIV and TB Program with funding from USAID. PSI provides program management.)

- Approximately 250 clients per week are seen when outreach is conducted.
- Once an outreach activity is started, monthly outreach is scheduled to address the window period issue and sustain demand and interest.
- It is essential to assess the proposed site to avoid sensitive locations such as churches and schools, and to ensure that the location is acceptable to the local community.
- It is crucial to assess the potential for adequate, effective community mobilization well in advance of the proposed dates of service provision, and to assess the level of assistance needed from PSI in terms of mobilization and implementation. Community mobilization should ensure that the employed and unemployed are served. This means there are actually at least six days, including a Saturday, for providing services, usually 9 a.m. to 3 p.m. Once dates are agreed upon, intensive community mobilization and advertising is arranged in the local media (if possible). Staff at the location to be used for VCT outreach are oriented on the program, the need for high-quality services and the importance of anonymity and confidentiality. Orientation is for *all* staff, including the security guards at the gates. Mobile services are offered for free because people often do not come when they are charged a fee. There has been higher HIV prevalence among clients reached through outreach services than among those reached at the fixed site. The outreach services also have accessed more marginalized clients than the fixed site.

The National Adolescent Friendly Clinic Initiative (NACFI) in South Africa

NACFI is a nationwide program developed to improve the quality of adolescent health care at the clinic level in South Africa by making clinics more adolescent-friendly. NACFI provides:

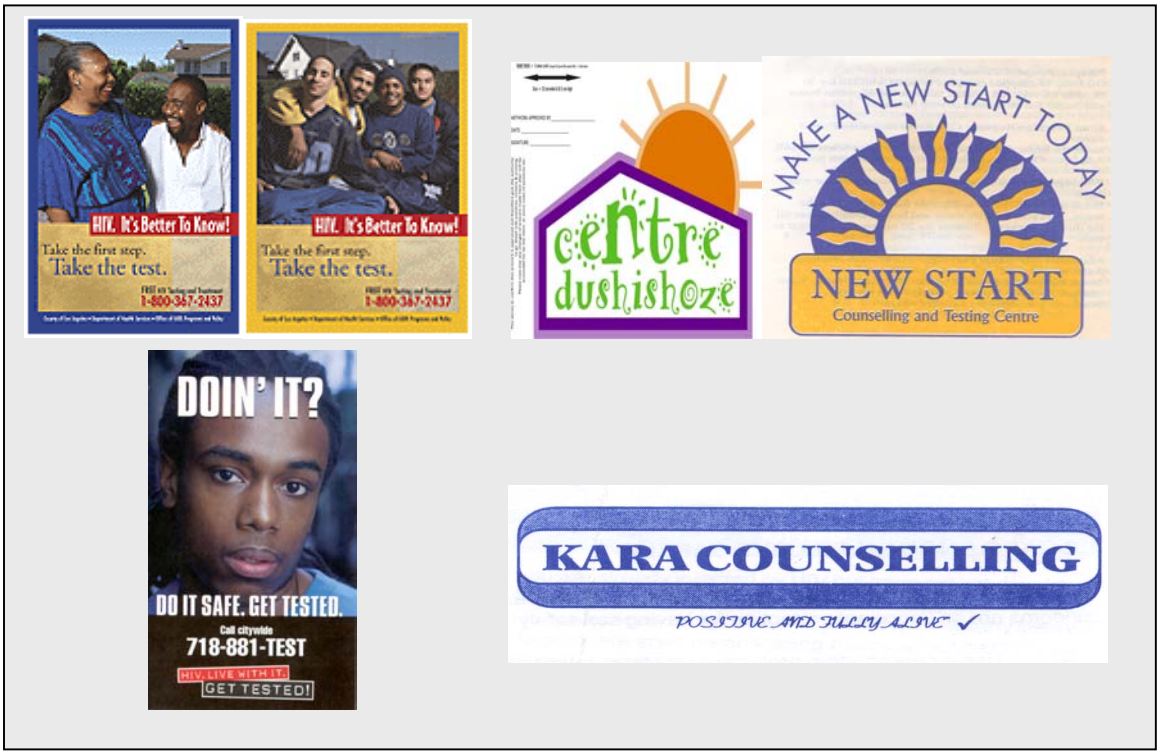
- Services at convenient times for adolescents
- Acceptable waiting times
- Adolescent-sensitive information, education and communication materials on sexual and reproductive health
- Information, counseling and appropriate referral for violence or abuse and mental health problems
- Contraceptive information and counseling, oral contraceptive pills, emergency contraception, injectables and condoms
- Pregnancy testing and counseling, antenatal and postnatal care
- Pre- and post-termination of pregnancy (TOP) counseling and referral
- Pre- and post-HIV test counseling and referrals for HIV testing

Personal communication with staff revealed that when a VCT intervention started at one site, the number of clinic attendees fell. This was reportedly due to clients' fears of coercion to be tested. This feedback demonstrates the importance of adequate community sensitization and promotion when integrating VCT within services. For more information: Telephone: (011) 933 1228; fax: (011) 933 1227.

STRATEGIES IN USE FOR PROMOTING VCT TO YOUNG PEOPLE

VCT communication messages: Promoting hope for the future appeals to young people

Communication messages must be designed with particular target audiences in mind. This will be of special importance in countries with localized epidemics that need to target hard-to-reach populations. There is widespread recognition that **fear tactics do not work** and may in fact perpetuate stigma and discrimination of PLHAs. VCT communication messages that have been directly related to the theme of hope and incorporate notions of the future, healthy attitudes (positive thinking/living) and safety are generally well received. The following are examples of existing VCT services:



Social marketing: attractive to young people

Social marketing is based on commercial marketing techniques. In social marketing campaigns, "social products"—such as condoms or (in this case) VCT services—are promoted. Social marketing programs have been effective in industrialized countries with long-term commitment and funding.[26] Social marketing has been applied more recently to HIV prevention and care interventions in developing countries.[27] Although socially marketed VCT has demonstrated attractive uptake figures, including access by young people, one of the major drawbacks is its cost-inefficiency and its poor replicability in settings or institutions that are not heavily subsidized by donors. In addition, some VCT social marketing approaches in Africa have so far focused their programming on individuals who test negative—thereby missing the significant opportunities for those most vulnerable to HIV transmission who also require targeting for increased access to prevention and care services. If social marketing is used, it is crucial that support services and mechanisms are also in place for those individuals who test positive.

Getting busy? HIV. Live with it. Get tested: VCT social marketing in the U.S.A.

Developed and piloted in New York, this social marketing campaign promoting counseling and testing focused on urban at-risk youth aged 13-24. The campaign was implemented in six cities in 1999: New York, Baltimore, Philadelphia, Washington D.C., Los Angeles and Miami.

Each city built a coalition offering free YFHS with confidential or anonymous HIV counseling and testing using an oral fluid antibody test (blood tests were also available), and a phone line for referrals and data collection. Youth who tested positive were provided with HIV care. At least 2,000 youth peer educators were trained and worked to promote the campaign in high-seroprevalence neighborhoods.

Paid advertising, dynamic IEC, youth-targeted materials and media coverage (leading daily newspapers, national and local television, radio and websites) were also used as marketing strategies. A 60-second television spot was created with Miami-based rapper Midnite. The campaign was kicked off with a conference targeting more than 500 health care providers, young people and physicians.

The campaign was successful in: strengthening coalitions among service providers; creating youth participation as outreach workers through training and small stipends; distributing more than 600,000 palm cards, fliers and magazines; accessing 2,774 hotline calls in six cities over six months; and creating regional sensitization of VCT for young people.

The campaign was less successful in: increasing uptake of testing by young people (462 young people tested during Get Tested Week) and obtaining access to newly HIV infected young people who could then be linked to care and support programs: 19 out of the 462 young people tested were newly HIV infected. In addition, a minimal number of calls translated into referrals.

For more information log onto www.HIVGetTested.com.[28]

BARRIERS TO VCT FOR YOUNG PEOPLE

- Availability and acceptability of VCT services, including legal issues
- Waiting time
- Costs and pressure by health staff to notify partners
- Worries about confidentiality and fear that results would be shared with parent(s) or partner(s) without their consent
- Inaccurate risk perception
- Fear of being labeled and stigmatized by their families, friends and communities
- Perceptions of the consequences of living with HIV
- Inadequate responses from health care providers, including counselors, to effectively meet the HIV prevention, care and support needs of youth

STRATEGIES TO INCREASE YOUNG PEOPLE'S USE OF VCT

Same-day services yield better return rates

Rate of return is correlated with capacity to provide same-day services. In some countries, individuals may still be required to wait up to two weeks for test results. In the United States, where same-day services are not available, only 63 percent of people who undergo HIV testing at publicly funded HIV testing centers returned for post-test counseling.[29] Young people and those from ethnic minorities were less likely to return for their HIV test result. People who attend freestanding VCT sites are more likely to return for post-test counseling than those who undergo VCT at STI or family planning clinics. Some pilot outreach services also report problems with rates of return. This can waste both money and staff time, and means that some people who test positive may not benefit from treatment options as well as post-test and follow-up counseling. Much higher proportions of those tested with simple/rapid testing will receive their HIV test result. Some VCT sites—usually those where quality counseling services and simple/rapid same-day services are offered—now have 100 percent return rates for test results.

Confidential versus anonymous testing

Most VCT services offer a ***confidential service*** in which the individual and his/her counselor share the test result. With confidential services, identifying information may be recorded—such as clients' name or the contact details within their records. Some countries may have a policy of reporting positive results to a referral center (named reporting) or a policy of partner notification. Name reporting is also important for sentinel surveillance of HIV within communities or countries. Reporting of some contact details can make it easy for a health care provider to offer follow-up and continuity of services.

Other VCT sites offer an ***anonymous service*** in which someone wanting a test can attend without giving his/her name. Anonymous services use only code names or numbers to ensure anonymity. Such services are more desirable among marginalized groups. Experience in industrialized countries such as the United States and Australia suggest that anonymous services may be more desirable to young people, including vulnerable and at-risk young people and young MSM. Other studies suggest that the introduction of anonymous testing increases uptake in higher-risk populations, such as IDUs.[30,31,32] Studies from the United States also have reported that ending anonymous services results in a decline in testing of vulnerable populations.[33,34] The main disadvantage of anonymous services is a lack of potential follow-up of clients to facilitate referral and support services.[35]

A study from the United States examined the effect of name reporting on the uptake of VCT services in publicly funded VCT programs, where approximately 2.5 million people are tested for HIV each year.[36] It was feared that the introduction of name reporting to aid surveillance would cause some individuals to avoid testing. But there was no significant effect on the use of testing facilities following the introduction of name reporting, though in some states there was a statistically insignificant reduction in testing among African-Americans and IDUs.

Reducing stigma

Stigma and discrimination affect uptake of VCT in different communities. Normalizing testing and increasing the number of people who know their serostatus is an important strategy for reducing stigma and discrimination. Similarly, the declaration of role models or valued members of the community that they have been tested is important in reducing stigma and increasing the uptake of HIV testing. When the athlete Magic Johnson announced he had been tested and was seropositive, there was a substantial increase in requests for VCT in the United States.[37]

Promoting hope

There is anecdotal evidence to support the notion that there must be a perceived benefit to testing if people are to be tested. For those who test positive, there must be a package of services to offer—otherwise there is no point in testing. In a qualitative evaluation of young people in Rwanda, some participants referred to an HIV-positive result as a "red card that is designed with a hoe and pick-axe" and believed that death is near.[38] In Eritrea, some health service providers refer to counselors as "angels of death."[39] These sentiments illustrate the negative impact of fear tactics rather than the necessary messages of hope.

The most successful VCT and care and support initiatives have marketed hope in their names, logos and value-added services: Hope House (VCT center) and Fountain of Hope (orphan project) in Lusaka, Zambia; New Start (VCT center) in Zimbabwe; Hope Humana (VCT center) in Ndola, Zambia; Hope Worldwide; Heroes of the Future (*Indatwa Z'ejo*, a youth magazine) in Rwanda; and Winning through Caring (BCC strategy) in Eritrea. Hope has also been successfully packaged by religious organizations. Church groups often provide outreach to AIDS patients during the terminal stage of their illness, a time when feelings of hopelessness may prevail. Hope must also be promoted by health providers who can help or hinder VCT and other care and support services. Service providers who themselves do not have hope create further barriers to VCT for their potential clients.

Ensuring supportive health provider responses and attitudes

The attitudes of health providers play a crucial role in addressing sexual issues with young people. Service providers who are inhibited may inhibit young clients who present to them, which creates additional access barriers. Unmarried but sexually active adolescents in Bangladesh reported that they did not feel comfortable seeking family planning or STI services from nearby clinics and pharmacies and perceived providers to be judgmental and unfriendly.[40]

In a qualitative follow-up of 100 counselors trained by Kara Counseling and Training Trust, 27 counselors said they felt uncomfortable counseling about sexuality-related issues. Nineteen of them specifically mentioned age as a barrier to their comfort level. This was true for both older counselors working with young people and young counselors working with their elders. Their comments revealed their attitudes:

- "I feel youth should not engage in sexual issues."
- "I cannot counsel my own daughter if she has a problem with her husband."
- "I cannot counsel people who are like my daughter."
- "I don't approve of giving condoms to people who are not married. The young people should use condoms but we shouldn't influence them to use them."
- "Those under 15, 14 years . . . I don't test."[41]

In a U.S.-based study by the Kaiser Family Foundation, young people noted that medical professionals did not discuss, offer or suggest testing when, according to teens themselves, they would have been open to that recommendation. Deterrents to youth seeking health care and HIV testing included the sense that medical officers and clinic workers do not respect youth or are judging them for being sexually active.

Cost factors: To reach most young people, VCT must be free

Services in Kenya, Zambia, Zimbabwe and the United States suggest that cost factors significantly affect uptake and acceptability of VCT services by young people.[42] Therefore, any attempt to introduce or scale-up VCT for young people must take cost analysis into consideration.

Operating hours: Flexible hours are more likely to provide accessibility

Uptake is also significantly affected by service operating hours. Many VCT sites have piloted operating hours to determine how best to cater to the needs of target groups. Approaches known to be effective with young people include:

- Offering services after hours (e.g., until 8 p.m.) as well as on weekends (Saturdays have been preferable in some countries with large Christian majorities).
- Offering youth or subgroup clinics on a particular afternoon or evening, which then become known by their time slot (e.g., "Tuesdays Clinic").
- Remaining open through lunch hour or lunch breaks in countries where business ceases between 12 p.m. and 2 p.m. When this occurs, services must address staffing to prevent burnout.

Legal issues: Supportive national guidelines and policies are needed

Age of consent for young people affects uptake of services

Most countries have legal requirements necessitating parental or guardian consent before *medical procedures* can be conducted. HIV testing may be subject to such legislation. VCT sites vary in their policies and practices for testing young people, depending on local and country polices. Many sites have not developed a formal policy on age of consent for testing, and in practice, procedures may be implemented at the discretion of the counselor on duty at the time. "Age of consent" is a contentious issue that confounds the ability to provide access to VCT as well as care and support in numerous circumstances.

Age of consent in Kenya

- In Kenya the legal age of consent is 18 years.
- Anyone 18 years and over requesting VCT is deemed able to give full, informed consent.
- For young people between 15 and 18 years, VCT may be provided if the counselor determines that the young person has sufficient maturity to understand the testing procedures and results.
- Young people between 15 and 18 years who are married and/or pregnant are considered "mature minors" who can give consent for VCT, though the counselor makes an independent assessment of the minor's maturity to receive VCT services. Children 14 years and under are given counseling if requested but should not be tested unless it is done for medical reasons, the counselor determines that VCT services have potential benefit for the minor and this is clearly explained to the minor.
- When children are brought to a VCT site for testing in Kenya, the counselor meets with the parents or guardians to determine the reasons for testing. VCT services are provided only if there is a clear potential benefit for the child, and the counselor determines that there is no potential for neglect or abuse of an HIV-positive child. Rwanda has formulated similar policy guidelines regarding age of consent for VCT.

What we know:

- Some young people are being denied access to VCT and clinical care on the basis of ageism (either based on provider judgment or policy restriction).
- In the absence of supportive policies, some service providers refer to generic policy guidance that endorses services for all (irrespective of gender, socio-economic status, age, etc.) as a way of ensuring service provision for young people.

Jamaica: Supportive policy reform

The Jamaican Ministry of Health amended its Reproductive Health Service Delivery Guidelines in 1999 to provide legal protection to health professionals wanting to provide information or services to youth below the legal age of consent (16 years), many of whom are already sexually active.[43]

Parental consent is a barrier to uptake of VCT by some young people (including those who could benefit from the intervention).

In California (United States), anyone 12 or older can give consent to test for HIV or other STIs.[44]

In Brazil, adolescents over the age of 12 have the same rights to health services as adults, and do not require parental consent to access services.

Some service providers withhold VCT from young people who request it through fear of parental retribution (in the absence of protective policy guidelines).

There are legal barriers to HIV education and counseling programs for young people in some countries. In the United States, for example, although recommendations have been made to provide age-appropriate HIV education and counseling for all school children, there have been legal actions to prevent this.[45] Barriers include lack of access to condoms and STI services for young people. Provision of such warrants acceptance of the fact that young people of varying ages are sexually active. Even in industrialized countries this reality has not been widely accepted by policymakers, including politicians.

What is needed:

- **Young people should be allowed to provide consent (without parental consent) for VCT.** Disclosure to parents should still be discussed during counseling and encouraged where young people have supportive relationships with parents. In addition, where young people are deemed to be at high risk, pre-test counseling needs to ensure adequate potential support systems if the result is positive, to ensure sufficient test decision-making outcomes.
- **Service providers should be able to provide VCT to young people who request it, without fear of retribution.**
- **National policy frameworks should support access to VCT for young people without parental consent, though parental support is encouraged where it is conducive to testing.** In the absence of a supportive parent, support by a trusted relative or friend is encouraged.

All stakeholders have a responsibility to continue to advocate for implementation of the Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child and all other global policies that promote access to health care and psychosocial support for children.

Legal ages of consent in six African countries

Country	Marriage	Identification registration	Medical treatment
Tanzania	15/16 female 19/20 male	18 driver's license	18
Malawi	18-20	18 driver's license	18
South Africa	16 for sex 21	16 ID registration 18 to vote and license	14
Zambia	18 16 customary law	16 ID registration 18 to vote	18
Mozambique	15/16 male 18 female	16 for passport 18 to vote	18
Zimbabwe	16, also for consent for sex	16 driver's license 18 to vote	18

POST-VCT OUTCOMES FOR YOUNG PEOPLE

Although studies have been designed to evaluate outcomes following VCT,[46] few look specifically at young people. For example:

- Does VCT help young people make therapeutic changes in their sexual behavior?
- How do young people who test seropositive cope? With whom do they share their test result? Who provides emotional support?
- Are young people able to access support services following VCT?
- What is the incidence of HIV over time among young people who initially test negative?
- What are the long-term outcomes for young people who undergo VCT?

Sexual behavior change following VCT requires further investigation

Studies have demonstrated that VCT is effective in promoting sexual behavior change in people attending VCT centers, but few studies have specifically looked at young people. A small descriptive study from Nigeria stated that the counseling service for young people increased uptake of condoms and decreased incidence of STIs.[47]

Three studies from the United States examined behavior change following VCT, with mixed results. One small study showed that VCT promoted a reduction in sexual partners among the majority of males, but none of the females reported increasing safe-sex practices.[48] A study from New Orleans among 4,031 economically disadvantaged black youth aged 15-25 showed mixed results following VCT.[49] The incidence of STIs following VCT did not change for young people who tested positive; although STI incidence decreased for those testing negative, it did not decrease for young people who had repeat HIV tests. In this study, HIV testing with individual pre- and post-test counseling was offered at a public STI clinic; quality of counseling and ongoing care may not have been as consistent as at VCT sites.

Another study from the United States examined behavior in the two years following VCT among "high-risk" young people attending an adolescent medical clinic in Washington D.C.[50] "Single- dose" VCT as offered in this setting did not result in any significant decrease in STIs or reduce risk behavior.

These studies suggest that offering VCT as part of medical care for young people at high risk of HIV infection in an industrialized country does not demonstrate consistent, successful behavioral outcomes.

Access to care must be strengthened

Approaches to care for young people still require considerable improvement, even in industrialized countries. It is estimated that only 11 percent of youth living with HIV in the United States receive adequate medical care.[51] More information is also needed on appropriate models of care for young people. Lessons from industrialized countries suggest that a one-stop shopping model of multi-disciplinary care with integrated services, including primary care, gynecological, HIV-specific, mental health and case management, is desirable to some groups of young people. However, this may not be realistic or achievable in many contexts. *Flexible appointments*, *attention to payment barriers* and *walk-in capacity* may facilitate participation in health services.[52]

ISSUES TO CONSIDER WHEN IMPLEMENTING VCT FOR YOUNG PEOPLE

Involving young people in designing, developing and promoting VCT services

Experiences from other health interventions have demonstrated the importance of involving young people in the design and development of services to ensure that they are relevant and acceptable. Young people should also be involved in ongoing monitoring and evaluation to ensure that services respond to their needs. Examples of youth involvement in four pivotal areas can be highlighted:

1. Youth as active members and leaders of post-test clubs, especially those that employ drama as an educative medium (Zambia, Uganda and Zimbabwe);
2. Youth, especially young men and young couples, as mobilizers for promotion of VCT within their respective communities (Zambia and Uganda);
3. Youth as Anti-AIDS Club leaders in schools and universities (Zambia and Uganda);
4. Youth as positive speakers (Zambia, Uganda, South Africa, Australia, United States).

Availability of ongoing emotional and support services

VCT for young people should be linked with support services following testing. These may include:

- Linkages with youth support groups;
- Involvement of and support from religious groups that advocate a holistic approach to AIDS prevention and care;
- Ongoing support for vulnerable young people, which may include IDUs;
- Adequate support for orphans, street kids and children-headed households.

In addition, the potential *role of schools* to provide support must be fostered and enhanced. Where participatory teaching methodologies are encouraged and experiential learning is promoted and modeled by teachers, young people may have opportunities to learn how to reduce their vulnerability to HIV.

Access to medical and HIV preventive care

For VCT to be acceptable, linkage with ongoing medical care should be considered, including:

- ARVs;
- Preventive therapies (TBPT and cotrimoxazole);

- PMTCT interventions;
- STI screening and treatment;
- Family planning/contraception;
- Access to condoms (male and female).

Pre-marital counseling

What we know:

- Pre-marital testing has the potential to help or hinder couples.

- Couples counseling for VCT is a valuable intervention when *truly voluntary* and when there is adequate *informed consent by both parties*.

- Pre-marital VCT is being widely promoted, particularly by churches and religious groups in sub-Saharan Africa.

- Some groups (including evangelical church groups) demand to cite test results as grounds to deny a marriage ceremony (where results are discordant or positive). Test result certification or documentation is not provided by most VCT sites because of the potential misuse or negative consequences, including stigma, discrimination and false hopes of "safety."

What is needed:

- **VCT should remain voluntary and couples should discuss in pre-test counseling the implications of discordant results.**

- **Safeguards and support systems for women must be ensured if they are at risk of discrimination, isolation, abandonment or abuse if found to be seropositive (as can occur with VCT associated with PMTCT interventions).**

- **There should be supportive policies on pre-marital testing—especially by religious bodies—to prevent stigma and discrimination on the basis of results.**

Mandatory testing

Although not VCT, it is necessary to highlight categories of mandatory testing that exist globally and that affect a sizeable number of young people. These include young people and adolescents who are:

- Planning to marry
- Planning to work, study or live abroad (temporarily or permanently)
- Planning to attend university (e.g., in Ecuador, mandatory HIV testing is a requirement for any prospective student attempting to gain entry to university within the country. Those who test positive will be denied entry)
- Refugees
- New military recruits (e.g., the China Peoples Liberation Army)
- Hoping to enter the seminary or convent (commonly practiced in high-prevalence parts of Africa though this may not be global protocol)
- Institutionalized, including orphanages, foster care, detention centers and prisons.

A common unfortunate feature of mandatory testing is the lack of supportive services offered after testing. The implication for these young people is particularly concerning, given that a positive result for most will

deny them access to their chosen life path. It is particularly important that support services (or, at the very least, linkages to support services) be created for young people in these situations. In addition, the international community may have a role in lobbying to amend some of these legal or guiding frameworks.

Young women and violence

Studies have found that fear of their male partners' violent reaction is a serious barrier to disclosure to women's disclosure of positive test results and that HIV-infected women are at increased risk of partner violence.[53] In a qualitative study conducted in Dar es Salaam, Tanzania, young HIV-positive women (18-29 years) were 10 times more likely to report partner violence than young HIV-negative women.[54]

In some countries, partner notification is required by law. Though there are only limited data, it is likely that such legislation would affect uptake of VCT services by some young women who may be at risk of abuse, isolation or abandonment following an HIV-positive result. A survey of 136 health care providers in Baltimore, United States, revealed that 24% of providers had at least one female patient who experienced physical violence following disclosure to a partner. More than one-third of all providers (38 % and 37%) had at least one female patient who experienced emotional abuse and abandonment following disclosure.[55]

What is needed:

- **Continued community-based efforts to address harmful attitudes and norms about sexuality and violence in parallel with any attempts to develop, expand or scale up VCT services for young people.**

- **Ensuring that partner notification strategies and legislation do not threaten the safety of HIV-positive women.**

Counselors for young people

Counselors who feel comfortable counseling adults do not necessarily feel comfortable counseling young people. Experience from many services illustrates that health workers are often authoritarian and judgmental when dealing with young people and have difficulty engaging and listening to their needs.

Counter-transference often features during observation of counseling and counseling role-play. Counselors may identify with young clients as their own children, grandchildren or younger siblings. This can pose significant challenges in their counseling roles as they may take on a role of "advisor" (which often includes instructing the young person to return to their parent for consent/advice, etc.) or "guide", rather than actively listening, supporting and suspending judgment. This has been cited among counselors in sub-Saharan and North Eastern Africa.

What is needed:

- **Counselors involved in providing VCT services for young people should be trained to work successfully with young people and to understand the role of transference and counter-transference in counseling, which has strong cross-cultural relevance for VCT.**

Peer counselors vs. peer educators: They are not the same

What we know:

- Young people can play clear and significant roles in designing and developing VCT services, mobilizing communities, advocacy, HIV and health education and ongoing support through post-test clubs and individual "buddy" schemes.

- The terms "peer educator" and "peer counselor" have been used loosely as if they were the same, when in fact the roles and skills bases of peer counselors may vary considerably from those of peer educators.

- Young people at many sites have been successfully trained in basic counseling skills, which can be used in providing emotional support and group work with peers, as well as in their own lives and surroundings.

What we suspect:

- While peer education has a documented role, it is usually not appropriate for youth peer educators to provide pre- and post-test counseling.

What is needed:

- **Service providers should seek the views of young people as to whom they would find most appropriate as counselors**.

In Eastern Europe, outreach peers (young former IDUs) were found to be effective in providing outreach education services for young drug users, but specially trained counselors were more acceptable in providing counseling around HIV testing.[56]

Research from Kenya and Uganda suggests that young people would prefer to be counseled by young adults, and not their peers (i.e., "not their friend and not their mother"). Most importantly, young people wish to feel that confidentiality will be ensured, and that the counselor is "on their level/close to young people." Some qualities young people look for in a counselor are "knowledge, trained, kind and a good communicator."[57]

Issues to consider for peer educators:

- Payment/allowances
- Training
- Support and supervision of peer educator activities
- Support and counseling for peer educators themselves
- Prevention of burnout
- Expanding the role of peer educators who have undergone VCT to play a role in community mobilization, post-test clubs and positive speaking (where the peer educator is HIV-positive and able to "go public" without suffering adverse consequences)
- Creation of job training or mentoring opportunities for young peer educators to encourage them to take on alternative roles, such as group facilitators, or to provide emotional support to other young people

Incentives for young people's participation:

- Involvement from the onset in design and planning
- Training opportunities
- Opportunities to address a range of audiences (e.g., a post-test club that creates drama skits requires opportunities to present at public forums to receive validation, affirmation and to give meaning to its efforts)
- "Edutainment," including prize giveaways and IEC materials
- Financial incentives
- Income-generating opportunities (these may also relate to skills-building activities)
- Skills-building activities (also highly valued by young people who are unemployed and/or out of school, and PLHAs)
- Involvement and appearances by youth icons (e.g., football players, rap musicians)
- Music
- Reimbursement for transportation
- Pens/notebooks/t-shirts
- Food/soft drinks

SUMMARY

Summary of issues to consider for acceptable and ethical VCT for young people

Disclosure to parent, guardian, family members, sexual partner(s)

Are staff adequately trained and competent to explore such issues during counseling? What service and/or national policies are in place in relation to disclosure? Are staff aware of the guiding policies?

Co*nsent* (legal and ethical considerations)

Who can provide consent? Under what conditions? Are staff consistent in addressing consent issues within a given service? Are staff aware of the legal and ethical framework in which they operate? Are they adequately trained to facilitate procedures relating to informed consent?

Confidentiality (anonymous vs. confidential VCT)

Does the service offer anonymous or confidential services? What is its experience with young people accessing the service? Is it feasible to modify services to increase access and uptake by youth (which may include revisiting confidentiality practices)?

Additional considerations:

- **There are no instant prescriptions for providing VCT to young people.** Learning by doing and expanded partnerships are needed to provide effective, innovative responses to the psychosocial needs of young people and children. To serve these needs requires investment in services besides VCT alone.

- **A range of innovative service delivery models can be applied, depending on the context.** These models may include freestanding sites or mobile services which, together with outreach models, show promise in increasing youth uptake of VCT. More information is needed on integrated non-health care setting models and mobile services models for vulnerable youth.

- **The chosen model must ensure adequate cost consideration to guarantee sustainability of services.** Service sustainability remains a challenge in many settings, especially non-integrated sites in which initial start-up costs are often provided by external international donors.

- **Strengthening the health sector is essential to facilitate better implementation of VCT services.** VCT is most effective as part of an integrated delivery system where related psychosocial, spiritual and medical services are part of the package of services immediately available to people presenting for VCT. This includes identifying or strengthening other care and support services including referral networks.

- **VCT must be accessible and affordable for those at highest risk of HIV infection or those suspected to have HIV-related illness.** VCT should be available to the range of young people who may benefit from knowing their HIV serostatus, including couples and individuals.

- **It is important to facilitate supportive policy development—including age of consent—for access to VCT, clinical and psychosocial care and follow-up support for young people.**

- **VCT services must be tailored to the unique epidemiological, behavioral and socioeconomic context of each country and setting.** Such designs must also take into account stigma-reduction and demand-creation interventions.

- **All aspects of VCT must facilitate beneficial disclosure.**

- **Sites must be adequately staffed by individuals with high-quality training in counseling and testing practices, supportive attitudes and practices towards young people, including marginalized sub-groups.**

- **VCT for couples must be widely encouraged and promoted.** Pre- and post-test counseling is beneficial for assessing risk and planning risk-reduction, including within PMTCT programs — in particular for women in countries where there is substantial gender inequity. In addition, targeting couples is cost-efficient.

- **VCT design must address service promotion in the planning and establishment of high-quality VCT services.**

- **A coordinated response by all stakeholders—including donors, government and non-governmental organizations (NGOs)—in establishing or scaling-up VCT programs to ensure standardized, high-quality care and support services and to avoid duplication of services within regions.**

ADVOCACY MESSAGES

- **Young people are not a homogenous population.** VCT programs and policies must target different subpopulations of youth with appropriate interventions as they relate to the epidemiological profile within a given country (e.g., target couples/singles aged 15-25/young IDU/young MSM [identifying or non-identifying], etc.).

- **VCT is an effective entry point to prevention and care services.** This is particularly pertinent in the current environment with increasing investment in antiretrovirals and prevention of mother to child transmission programs.

- **Strategies that normalize testing by reducing stigma and discrimination will increase acceptability and decrease barriers to VCT.**

- **Access to testing is increased by supportive policies on age of consent for VCT, prevention and care interventions, affordability, confidential and convenient locations and hours.**

- **Adhering to test result confidentiality and continuing to strengthen primary health care services, MCH services, health delivery infrastructure and personnel capacity will increase access and uptake of VCT services.**

- **Efforts should be continued to increase access to health care by children and young people.**

- **Linkages and referral systems should be increased across the health sector as well as with other key providers (legal, religious, psychosocial, financial).**

- **There is no one right way to provide VCT for young people *per se*.**

- **Counseling for young people should not be "one off" interventions.** It takes time to develop rapport with young people and to gain trust. Capacity to promote sustainable behavior change is only likely to occur when more than one session is provided.

- **Be cautious in attempting to translate lessons from dissimilar contexts** (e.g., from the United States to Africa, Asia to Africa, Africa to Europe) by giving thorough consideration to the range of variables at play, including: socioeconomic, gender relations, service delivery infrastructure capacity, nature of the epidemic, health priorities, political and legislative framework.

- **Ongoing investment is needed in VCT services within antenatal contexts (in high and emerging prevalence settings).**

- **"Learning by doing" should continue in a planned, coordinated manner.**

- **Lessons learned about VCT for young people should be documented.**

- **Emerging service delivery models should be evaluated**.

STRATEGIES TO SUPPORT VCT FOR YOUNG PEOPLE

What needs to be done	How to do it
Increase access and acceptability of VCT for young people including young couples.	▪ Train and/or retrain health care service providers and counselors to work more effectively with youth in providing VCT and HIV care and support. ▪ Work with ministries of education to include promotion of VCT benefits for young people within existing life-skills training and other related educational curricula. ▪ Work with relevant line ministries (e.g., ministries of health) to enhance and/or revise protocol to improve access to health services for young people. Re-visitation of policy guidance must explore issues relating to capacity for young people to give informed consent for VCT (without requiring parental approval/consent). ▪ Support innovative VCT promotional campaigns targeted to young people or subgroups of young people (e.g. couples, youth at risk, young men, etc.). ▪ Develop communication materials targeting young people or subgroups of young people at national levels, as appropriate.
Advocate for rights-based frameworks for access to health care and psychosocial support .	▪ Advocate for supportive policy frameworks and flexibility of interpretation of legal guidelines to encourage young people and adolescents to be able to access VCT as well as medical and psychological care and support.
Make counseling and follow-up support for young people a higher priority.	▪ Ongoing emotional support can be provided by post-test clubs, individually tailored care and through referral to other agencies. Young people not only have HIV-related counseling needs but may also require help for other problems. Some needs may also be addressed through group peer support.
Ensure access to factual information, skills-building opportunities and referral agencies.	▪ Life-skills training and VCT should be mutually reinforcing approaches. Young people must have opportunities to obtain information on modes or transmission, accurately assess their potential risk practices and be given opportunities to practice skills to reduce risk and to modify harmful behaviors as desired.

What needs to be done	How to do it
Continue to strengthen the "youth-friendliness" of health services and meet young people's needs for family planning, STI and HIV care, and linkages to them.	▪ Strengthen comprehensive medical care within existing services as well as learning sites for family planning, reproductive health, antenatal services for young pregnant women. STI and HIV care (including specific services such as preventive therapy, treatment of opportunistic infections, STIs, ARV therapy, etc.). Linkages with youth-friendly health services by potential referral services and visa versa are essential. How access to ARVs for positive symptomatic young people will be organized requires further planning. Young people will require ongoing counseling to help them with *adherence* to ARVs to help *cope with adverse effects, and to uphold positive living practices.* ▪ In-depth critical evaluation of existing youth-friendly health services is required which explores levels of uptake and strategies addressing uptake by young people to date. Where successful models that could be replicated are identified (especially those demonstrating broad coverage and comprehensive service provision with VCT, potential to offer VCT, or direct linkages to such), these should be documented and widely disseminated.
Develop innovative ways to reach marginalized young people.	In countries with low prevalence or concentrated epidemics[1] the priority is to provide HIV prevention and care services for young people who are particularly vulnerable to HIV infection. Groups to be targeted depend on local factors and should be based on formative research. VCT should not be confined to pre- and post-test counseling but also includes supportive counseling to address underlying vulnerabilities and risk behaviors. When targeting particular groups, it is important not to increase marginalization and stigma that may already exist. This can be avoided through implementation of outreach and mobile service delivery models while lobbying for supportive policy frameworks.
Support initiatives led by and involving positive and negative youth.	Support anti-AIDS clubs, youth ambassador programs, post-test clubs, drama clubs and edutainment initiatives that involve young people in fighting stigma and discrimination.

[1] UNAIDS/WHO HIV epidemic definitions:
1. **Low-level:** below 1 percent in the general population, under 5 percent in high-risk groups.
2. **Concentrated:** below 1 percent in the general population, over 5 percent in high-risk groups.
3. **Generalized:** more than 1 percent in the general population.

SUGGESTED READING

Boswell, D and Baggaley R. *Voluntary Counseling and Testing: A Reference Guide.* Responding to the Needs of Young People, Children, Pregnant Women and their Partners. Arlington, VA: Family Health International, 2002. Soon to be available at <www.fhi.org>.

Horizons. *HIV Voluntary Counseling and Testing Among Youth Ages 14 to 21. Results from an Exploratory Study in Nairobi, Kenya and Kampala and Masaka, Uganda.* 2001. Available at <www.popcoucil.org/horizons/horizonsreports.html>.

UNAIDS. *HIV Voluntary Counseling and Testing: A Gateway to Prevention and Care.* 2002. Five case studies related to prevention of mother-to-child transmission of HIV, tuberculosis, young people and reaching general population groups.

WHO/UNAIDS. Technical Consultation on Voluntary HIV Counseling and Testing: Models for Implementation and Strategies for Scaling of VCT Services Harare, Zimbabwe 3-6 July 2001. 2002. Available at <http://www.unaids.org/publications/documents/health/counselling/vct-report-harare.doc>.

Magombe, et al. *Extension of HIV Counseling and Testing in Rural Sites: The Ugandan Experience.* International AIDS Conference, 1998 (Abstract #13247).

Arthur G, et al. *Feasibility and Accessibility of VCT Services Integrated Within Health Centers in Kenya: Proceeding of the Consultative Technical Meeting on Voluntary Counseling and Testing (VCT).* Family Health International/IMPACT Kenya. Nairobi, Kenya. September 7-8, 2000.

UNAIDS Case Study. *Knowledge is Power: Voluntary HIV Counseling and Testing in Uganda,* 1999.

UNAIDS. *The Impact of Voluntary Counseling and Testing – A Global Review of the Benefits and Challenges.* UNAIDS Best Practice Collection, June 2001.

Family Health International. *A Guide to Establishing Voluntary Counselling and Testing Services for HIV.* Arlington, VA: Family Health International, 2002. Soon to be available at <www.fhi.org>.

Family Health International. *Evaluating HIV Counseling and Testing in Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision-Makers.* Arlington, VA: Family Health International, 2002.

The Voluntary HIV-Counseling and Testing Efficacy Group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: A randomised trial. *Lancet* July 8, 2000.

Sweat, et al. Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV-1, Kenya and Tanzania. *Lancet* July 8, 2000.

WHO. *Voluntary Counseling and Testing for HIV Infection in Antenatal Care: Practical Considerations for Implemenation.* WHO/HIS/00.05. Geneva: World Health Organization, September 1999.

REFERENCES

[1] Panos Briefing #35, *Young Lives at Risk – Adolescents and Sexual Health*. July 1999. <www.panos.org/uk/briefing/young_lives_at_risk.htm>.

[2] WHO/UNAIDS (2000), and *Youth and HIV/AIDS: Forces for Change. New York:* UNICEF, 1998.

[3] United Nations. *Sex and Age Distribution of the World Population: The 1998 Revisions*. New York: Population Division, Department of Economics and Social Affairs of the United Nations Secretariat, 1999.

[4] Office of National AIDS Policy. *Youth and HIV/AIDS 2000: A New American Agenda.* Washington, D.C.: The White House, September 2000.

[5] Bohmer L and Kirumira E. *Final Report: Access to Reproductive Health Services Participatory Research with Ugandan Adolescents.* Pacific Institute for Women's Health, Los Angeles, CA, and The Child Health and Development Center, Makarere University, Kampala, Uganda, 1997.

[6] Dehne KL, Grund JP, Khodakevich, Kobyshcha Y. The HIV/AIDS epidemic among drug injectors in Eastern Europe: Patterns, trends and determinants. *Journal of Drug Issues* 1999; 29(4): 729-756.

[7] NACA Mid-term Plan, 2001-2005.

[8] Nabwiso F, Moore M, Tukwasiibwe E, Marum E, Higgins D. *HIV Counseling and Testing (CT) in Young Ugandans.* Abstract PO-C25-3215, presented at the IXth International AIDS Conference, Berlin, Germany, 1993.

[9] Kakooza A. *Attitudes of Young People to Counseling Services and HIV Screening and Testing.* Abstract PO-D-5325, presented at the VIIIth International AIDS Conference, Amsterdam, Holland, 1992.

[10] Gumisiriza E, Alwano-Edyegu M, Baryarama F, Kalule J, Marum E, Moore M. *Response of Young People 15-19 to HIV Counseling and Testing in Uganda.* Abstract TU-C333, presented at the XIth International AIDS Conference, Vancouver, Canada, 1996.

[11] Hope Humana. Annual Report, 2001.

[12] Gomes M, Ferreira M, Silva C, Silva S. *Testing and Counseling Adolescents – Rio de Janeiro, Brazil.* Abstract B5170, presented at the XIIIth International AIDS Conference, Durban, South Africa, 2000.

[13] Dillon B, CDC, 1999.

[14] Villarosa, L. A New Generation: Teenagers Living With HIV. *New York Times*, November 20, 2001.

[15] WHO Technical Consultation on VCT. Meeting Report. Harare, Zimbabwe, July 3-6, 2001.

[16] Strathdee SA, Hogg RS, Martindale SL, Cornelisse PG, Craib KJ, Montaner JS, O'Shaughnessy MV, Schechter MT. Determinants of sexual risk-taking among young HIV-negative gay and bisexual men. *J AIDS and Human Retrovirology* 1998; 19(1): 61-6.

[17] Newens AJ, McEwan R. AIDS/HIV awareness training for young people with severe learning difficulties: An evaluation of two school programs. *J Advanced Nursing* 1995; 22(2): 267-75.

[18] Horizons. *HIV Voluntary Counseling and Testing Among Youth Ages 14-21: Results from an Exploratory Study in Nairobi, Kenya, and Kampala and Masaka, Uganda,* 2001.

[19] Mirza T, Kovacs GT, McDonald P. The use of reproductive health services by young women in Australia. *Australia & New Zealand Journal of Obstetrics and Gynaecology* 1998, 38(3): 336-8.

[20] Rotheram-Borus MJ, O'Keefe Z, Kracker R, Foo HH. Prevention of HIV among adolescents. *Prevention Science* 2000; 1(1): 15-30.

[21] WHO proposal to the United Nations Foundation. *Young people and VCT for Zambia and Nigeria.* May 2000**.**

[22] Henry-Reid LM, Rodriguez F, Bell MA, Martinez J, Peera A. Youth counseled for HIV testing at school- and hospital-based clinics. *J National Medical Association* 1998; 90(5): 287-292.

[23] DeRiemer K, Soares EC, Dias SM, Cavalcante SC. HIV testing among tuberculosis patients in the era of antiretroviral therapy: A population-based study in Brazil. *Intl J Tuberculosis and Lung Disease* 1998; 4(6): 519-27.

[24] Stephens T, Braithwaite RL, Taylor SE. Model for using hip-hop music for small group HIV/AIDS prevention counseling with African-American adolescents and young adults. *Patient Education and Counseling* 1998; 35(2): 127-37.

[25] Alawuru P, Osahwanurhu M, Okoro. *AIDS Clinic Outreach to Private Medical Centres: The Nigerian Experience.* Abstract 13479, presented at the XIIth International AIDS Conference, Geneva, Switzerland, 1998.

[26] Cohen D, Farley T, Bedimo-Etame J, Scribner R, Ward W. Implementation of condom social marketing in Louisiana. *Am J Public Health* 1999; 89(2): 204-8.

[27] Svenkerud P, Singhal A. Enhancing the effectiveness of HIV/AIDS prevention programs targeted to unique population groups in Thailand: Lessons learned from applying concepts of diffusion of innovation and social marketing. *J Health Communication* 1998; 3(3): 193-216.

[28] Futterman D, Peralta L, Rudy B, Wolfson C, Guttmacher S, Rogers A. The Access Project: Social marketing to promote HIV testing to adolescents, methods and first year results from a six-city campaign. *J Adolescent Health* 2001.

[29] Valdiserri RO, Moore M, Gerber AR, Campbell CH Jr, Dillon BA, West GR. A study of clients returning for counseling after HIV testing: Implications for improving rates of return. *Pub Health Reports* 1993; 108(1): 8-12.

[30] Fehrs L, Fleming D, Foster L. Trial of anonymous vs. confidential HIV testing. *Lancet* 1988; 2: 379-382.

[31] Hoxworth T, Hoffmann R, Cohn D, Davidson A. Anonymous HIV testing: Does it attract clients who would not seek confidential testing? *AIDS Pub Policy J* 1994; 9: 182-189.

[32] Hirano D, Gellert G, Fleming K, Boyd D, Englender S, Hawkes H. Anonymous testing: The impact on demand in Arizona. *Am J Pub Health* 1994; 84: 2008-2010.

[33] Hertz-Picciotto I, Lee L, Hoyo C. HIV test-seeking before and after restriction of anonymous testing in North Carolina. *Am J Pub Health* 1996; 86: 1446-1450.

[34] Irwin K, Valdiserri R, Holmberg S. The acceptability of voluntary HIV antibody testing in the United States: A decade of lessons learned. *AIDS* 1996; 10: 1707-1717.

[35] Futterman D, Chabon B, Hoffman ND. HIV and AIDS in adolescence. *Ped Clinics of N America* 2000; 47(1): 171-188.

[36] Nakashima A, Horsley R, Frey R, Sweeney P, Weber J, Fleming P. Effect of HIV reporting by name on the use of publicly funded counseling and testing programs. *JAMA* 1998; 280(16): 1421-6.

[37] CDC. Sexual risk behaviors of STD clinic patients before and after Ervin "Magic" Johnson's HIV-infection announcement. *Morbidity and Mortality Weekly Report* 1993; 41: 45-48.

[38] FHI/IMPACT. Programme de Prevention du VIH/SIDA Aupres des Jeunes du Diocese de Byumba. Rapport d'Evaluation Qualitative de Base. May 2000.

[39] Eritrea MOH/NACP. Personal communication, 2001.

[40] Bhuiya, et al. *Reproductive Health Service for Adolescents: Recent Experiences from a Pilot Project in Bangladesh.* Paper presented at the International Conference on Adolescent Reproductive Health: Evidence and Program Implications for South Asia, Mumbai, Nov. 1-4, 2000.

[41] Boswell D, Kakonge, L.M, Kasonde, F. *Are the Counselors Counseling? The Impact of Counseling Training in Lusaka and Reflections from the Field.* Report and abstract presented at ICASA, Lusaka, Zambia, September 1999.

[42] Damesyn M, Stiehm ER, Neuman CG, Morisky D, Omwomo WO. *Locally Sustainable Administration of HIV Counseling and Testing to Young Couples in Rural Regions of Western Kenya.* Abstract.

[43] Ministry of Health and National Family Planning Board. *Jamaica Family Planning Service Delivery Guidelines.* Kingston, Jamaica, 1999.

[44] State of California, Department of Health Services. *HIV Counseling and Testing Guidelines: Policies and Recommendations,* 1997.

[45] Brown EJ, Simpson EM. Comprehensive STD/HIV prevention education targeting U.S. adolescents: Review of an ethical dilemma and proposed ethical framework. *J Nursing Ethics* 2000; 7(4): 339-349.

[46] UNAIDS. *The Impact of Voluntary Counseling and Testing: A Global Review of the Benefits and Challenges,* 2000. UNAIDS 01.32E. Available at <http://www.unaids.org>.

[47] Ita M. *Counseling in Reproductive Health Among Young People in the Shitta Community in Lagos State.* Abstract 60857, presented at the XIIth International AIDS Conference, Geneva, Switzerland, 1998.

[48] Flutterman D, Hein K, Kipke M. *HIV-positive Adolescents: HIV Testing Experiences and Changes in Risk-related Sexual and Drug Use Behavior.* Presented at the VIth International AIDS Conference, San Francisco, CA, 1990.

[49] Chamot E, Coughlin SS, Farley TA, Rice JC. Gonorrhoea incidence and HIV testing and counseling among adolescents and young adults seen at a clinic for sexually transmitted diseases. *AIDS* 1999; 13(8): 971-9.

[50] Clark LR, Brasseux C, Richmond D, Getson P, D'Angelo LJ. Effect of HIV counseling and testing on sexually transmitted diseases and condom use in an urban adolescent population. *Arch Ped & Adol Med* 1998; 152(3): 269-73.

[51] Office of National AIDS Policy. *Youth and HIV/AIDS 2000: A New American Agenda.* Washington, D.C.: The White House, September 2000.

[52] Futterman D, Chabon B, Hoffman ND. HIV and AIDS in adolescence. *Ped Clinics N America* 2000; 47(1): 171-188.

[53] Gielen, et al, 1997; Rothenberg, et al, 1995; Temmerman, et al, 1995.

[54] Maman S, et al. *HIV and Partner Violence: Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam, Tanzania*, 2001

[55] Rothenberg K, Paskey S, Reuland M, Zimmerman S, North R. *Domestic Violence and Partner Notification: Implications for Treatment and Counseling of Women with HIV*. May/August 1995.

[56] *WHO Technical Consultation on VCT, Meeting Consultation Report.* July 3-6, 2001.

[57] Horizons. *HIV Voluntary Counseling and Testing Among Youth Ages 14-21: Results from an Exploratory Study in Nairobi, Kenya, and Kampala and Masaka, Uganda,* 2001.